Questions and Answers
from recent DMA and DMH/DD/SAS Service Definitions Training

February 24, 2006
Amended March 13, 2006

[Answers amended to numbers
12, 52, 57, 66, 67, 75, 90, 91, 221, 222, 223, 225, 229, 231, and 233.]

No.	Category	Question	Answer
1	Assertive Community Treatment Team (ACTT)	How are ACTT services coordinated with natural supports to avoid negative impacts?	ACTT is very successful in re-connecting consumers to family members. Natural supports are used with the consent of the consumer so any negative impact should be minimal. As with any coordination of services, there may be conflicts or issues to be resolved – this is why open communication is so important to quality care and treatment.
2	Advanced Practice Nurses	What services will advanced practice nurses be able to provide and when will advanced practice nurses be able to bill for the services?	The Division of Medical Assistance is in the process of implementing new services. We have indicated the services that can be provided by nurse practitioners and psychiatric clinical nurse specialists. Please contact us with additional information about services you provide that we have not addressed.
3	Authorization	Most the enhanced services require prior authorization. Will there be a standard authorization request form for enhanced services?	Prior authorizations forms and processes will be standardized and statewide.
4	Authorization	We have been told that if a client has both private insurance and Medicaid, the insurance denial must occur prior to obtaining prior authorization for the service from Medicaid. But without prior authorization we cannot bill Medicaid after a service and insurance billing was denied.	If you know the service requires prior authorization, you need to request PA prior to providing the service. If PA is required by the primary insurance carrier, you must indicate that you have requested PA from the primary payer. This will ensure that if our vendor is notified that the primary payer denied payment, your request will be processed in a timely manner. System changes to override Medicare and Third Party limits for these enhanced services have been implemented where Medicare or THIRD PARTY LIABILITY coverage is known to not exist.
5	Authorization	What is the $ .08-cent charge listed on the Remittance and Status Advice?	This is the transaction fee that Medicaid charges for interactive recipient eligibility verification transactions. Please refer to page 10-3 of the Basic Medicaid Billing Guide for additional information.

6	Authorization	Once we receive our endorsement, will we continue to submit prior authorization requests to the Local Management Entity?	Information regarding prior authorization will be forth coming.
7	Authorization	If basic services have been authorized for a consumer but there is a need for additional services, will enhance services be automatically authorized?	Requests are reviewed for re-authorization on a case specific basis. The type of service requested should be based upon the needs of the individual, not the authorization process. The clinician should consider if a more enhanced service is appropriate but that is dependent upon the clinical needs of the person served.
8	Authorization	How should authorization for new services be handled when services are implemented on March 20?	The Department will issue more guidance and direction on authorization.
9	Authorization	Regarding the resolution of an eligibility denial by submitting a copy of the Medicaid identification card, what happens if our facility has requested the Medicaid card every time a consumer presents for services but they fail to provide it. How can you resolve this issue?	Although the recipient's Medicaid identification card is the most expedient method for eligibility verification, eligibility can also be verified using the Automated Voice Response System or Electronic Data Interchange interactive eligibility verification programs. Please refer to the Basic Medicaid Billing Guide for additional information.
10	Basic Benefit	Where do individual therapy, family therapy, and group therapy services fall under the enhanced benefits/reform?	If a consumer's approved person-centered plan (PCP) identifies an enhanced benefit service and there is also clear medical necessity, one of these services could be authorized.
11	Billing	Can we expect window 2 classes-billing by Local Management Entity to close too?	Yes will close with dates of service 5/31/06
12	Billing	Some codes (day treatment, ACT, SAIOP) do not change but have new services definitions. May a provider continue to bill through the Local Management Entity during the transition period until that provider has completed endorsement and direct enrollment, at which time they will bill directly?	**Revised 3/13/06** Transition information was provided in a DMH/DMA communication letter dated January 19, 2006. Refer to Enhanced Services Implementation Update #1 on DMH's website at http://www.dhhs.state.nc.us/mhddsas/announce/index.htm Note: On March 6, 2006, recipients currently receiving both ACTT and Psychosocial Rehabilitation were provided in writing the opportunity to select one or the other service, by March 16, 2006. See notice A-1, *Notice to Adults Receiving Assertive Community Treatment Team and Psychosocial Rehabilitation* posted on 2/28/06 at http://www.dhhs.state.nc.us/mhddsas/announce/index.htm

13	Billing	What are the final rates for the new Service Definitions? How do we get the rates?	The Mental Health Enhanced Services Rate Schedule for 2006_ is available on DMA's website at http://www.dhhs.state.nc.us/dma/fee/mhfee/
14	Billing	Where are the covered procedure codes listed?	The HCPCS procedure codes are listed in a the September 2005 and January 2006 special bulletins (http://www.dhhs.state.nc.us/dma/bulletin.htm) along with the definition summaries.
15	Billing	Do you have to submit documentation with the Health Insurance Information Referral Form (DMA-2057)?	Yes. An EOB or a copy of the recipient's health insurance card must be attached to the form. Please refer to the Basic Medicaid Billing Guide for additional information.
16	Billing	Will there be a different billing number for every service?	Yes. In addition, each site will have a core group billing provider number and a service specific attending number for each service endorsed and enrolled. Therefore, one group number is assigned per site, but possibly multiple service specific attending numbers.
17	Billing	When can I begin billing services that were implemented as part of Phase I on September 1, 2005?	If endorsed by the LME and enrolled with Medicaid, providers can start billing with dates of service March 20, 2006.
18	Billing	How will opiod treatment be billed as an event?	Opiod treatment is for Methadone administration and Methadone administration is per event.
19	Billing	If direct billing outpatient and the provider does not want to provide any enhanced services, then we do not need to do anything-right?	Correct
20	Billing	Can IPRS dollars be used for non-enhanced services?	Services paid for through IPRS will be included in an updated array of services.
21	Billing	When HE ends, what is the format for authorization?	If you are referring to the modifier on the end of the case management code, there will be no authorization as the service can no longer be provided. Case Management is no longer a "stand alone" service and has been included as a component of several enhanced services.
22	Billing	How long can providers bill thru LME's?	Transition information was provided in a DMH/DMA communication letter dated January 19, 2006. Refer to Enhanced Services Implementation Update #1 on

			DMH's website at http://www.dhhs.state.nc.us/mhddsas/announce/index.htm
23	Billing	Is the Fee Schedule on the website correct?	The Mental Health Enhanced Services Rate Schedule for 2006 is now available on DMA's website at http://www.dhhs.state.nc.us/dma/fee/mhfee/
24	Billing	Currently, you must be direct enrolled to bill Medicaid. Will billing for the enhanced services work the same way?	Everyone will need to be direct enrolled to provide enhanced benefit services, including the LMEs that will be service providers
25	Billing	If billing multiple services, can you add multiple alpha suffixes to the attending provider number? Will you get multiple RAs?	If you are billing multiple services, you must submit one claim for each service if they are billed under different alpha suffixes. You can only have one alpha suffix on an attending number at a time. You will not receive multiple RAs because you are still using one group billing provider number and this is the number that the monies are paid to and the financial information is filed under.
26	Billing	If a child is approved for over services beyond the limit, does the agency bill the same way?	To date, all of the details for billing have not been finalized with EDS. At this time, we are anticipating that DMA will have to provide approval in order for EDS to pay the claim manually approve to claim to allow EDS to date, but it looks like DMA will have to send a memo to EDS to allow the claim to process.
27	Billing	How will current services be billed when phase III is implemented at the end of May.	You will need to be endorsed and enrolled with Medicaid by the end of May. If you are endorsed and enrolled by March 20, you may direct bill for services provided on that date of service and forward. Refer to the DMH/DMA communication letter dated January 19, 2006 for additional information. (http://www.dhhs.state.nc.us/mhddsas/announce/servdefimplementation1-19-06dmadmh-memo.pdf)
28	Billing	Does Medicaid reimburse for treatment team meetings?	No. Medicaid does not reimburse treatment team meeting time
29	Billing	Can individual providers bill for Substance Abuse Intensive Outpatient Program	No. This is a licensed facility based service

		services?	
30	Billing	Why can services only be provided by facilities with no more than 15 beds?	Federal regulations do not allow Medicaid to reimburse for residential or any inpatient services for adults (ages 22 through 64) in facilities that have move then 16 beds. They are considered Institutions for Mental Diseases and there are no federal dollars for this level of care
31	Billing	Is client choice an acceptable reason for an override for Third Party Liability?	No. Client choice is not a reason to override THIRD PARTY LIABILITY. Medicaid is payer of last resort.
32	Billing	If you have provided service to a recipient with Medicaid for Pregnant Women and payment was denied, can you bill the recipient??	The only time that it is acceptable to bill a recipient after billing Medicaid is when the payment is denied with one of the following Estimates of Billing (EOBs): 11, 525, 953, 1895. Refer to the Basic Medicaid Billing Guide for additional information on billing a recipient.
33	Billing	When billing a claim for a group, does the attending provider have to sign the claim or can the group authorize one of their members to be responsible for signing the claims?	Whoever is authorized to sign claims for the agency can sign the claim or complete the Certification for Signature on File Form.
34	Billing	What is purpose of appending the alpha to the provider number?	The alpha corresponds to the service being provided.
35	Billing	Can the DSM diagnosis be used on the claim instead of an ICD-9-CM diagnosis code?	Yes. The system will convert a DSM V to a ICD-9-CM diagnosis code.
36		Deliberately left blank	Deliberately left blank
37	Billing	Which enhanced services will IPRS pay for and will the Service Definition need to be adhered to in order for IPRS to pay for the service?	Services paid for through IPRS will be included in an updated array of services.
38	Billing	What codes can be billed in addition to CPT code 90801 for CPT II or CRS (Connors Report Scales, Connors Continuous Performance Task) now that CPT code 96100 has been end-dated?	You can bill psychological testing codes in addition to 90801 psychiatric interviews. The testing codes, however have changed, please refer to the January 2005 general Medicaid bulletin.
39	Billing	Will the Local Management Entity billing provider number 3404 work for Enhanced Services?	No. The LME is required to enroll each site for each service to be provided according to the same guidelines and requirements as other providers.

40	Billing	Does Medicaid cover outpatient treatment billed with V codes? (i.e., parent-child relational problem).	There are certain conditions in which the V codes can be used for billing services. They are listed in the December 2001 Special Bulletin for mental health services. Please note that there is a limit to how many visits can be billed with a V code for outpatient therapy.
41	Billing	Are there any changes in the way hospitals should bill for current services not listed in the new service definition? For example, inpatient psychiatry?	No.
42	Billing	Do the new service definitions apply to Health Choice clients? CMSED/IPRS? State Employees Insurance?	For information about State Employees Health Plan, please contact the Health Plan. Health Choice is reviewing the service definitions and will notify providers when a decision has been reached.
43	Billing	Who is responsible for updating and maintaining third party insurance information and the third party insurance code book?	The Division of Medical Assistance's Third Party Recovery unit updates the Third Party Insurance Code Book
44	CAP-MR/DD	Do providers need to re-enroll and receive a new provider number in order to provide CAP-MR/DD services?	Agencies and LMEs that were providing CAP-MR/DD waiver services under the old waiver do not need to re-enroll to provide services implemented by the new waiver on September 1, 2005. No action is required to provide a new service that directly cross-walked to the new waiver. However, two new services did not crosswalk from the old waiver: Day Supports and Residential Supports. Therefore, providers must update their enrollment with Medicaid to provide these services. New providers of CAP services must complete the provider enrollment process and, until the endorsement phase opens for CAP, go through the certification review with the LME for submission of their packet. For additional enrollment information, refer to DMA's website at http://www.dhhs.state.nc.us/dma/Forms/provenroll/cap.htm.
45	CAP-MR/DD	Please clarify the supervision	According to 10A NCAC 27G.0104,

		requirements for CAP-MR/DD. Can an associate professional supervise a paraprofessional?	"Supervision shall be provided by a qualified professional or associate professional with the population served." .
46	CAP-MR/DD	When will site-specific endorsement checklists be available for CAP-MR/DD services.?	Checklists for CAP-MR/DD services will be provided in advance of the endorsement phase for CAP.
47	CAP-MR/DD	Accreditation – CAP MR/DD – yes or no in 3 years?	Yes.
48	CAP-MR/DD	CAP MR/DD on-call, phone coverage sufficient? or must be face to face? first responder??	CAP-MR/DD Plans of Care require both clear processes for back-up staff in case of emergency as well as crisis planning. Case managers are considered to be first responder for developmental disabilities.
49	CAP-MR/DD	Is the recipient's date of birth required to be written on the service record? Is the recipient's Medicaid identification number required to be written on the service record?	The recipient's date of birth does NOT have to be written on each page of the CAP plans. As far as the MID, it is on the first page of the POC for CAP.
50	CAP-MR/DD	Do providers need to get a third party insurance denial before they bill Medicaid for services?	Third party insurance denial is required only for Specialized Equipment and Supplies and Specialized Consultative Services.
51	CAP-MR/DD	Do EPSDT regulations apply to CAP-MR/DD services?	No. EPSDT regulations for children do not apply to waiver services.
52	CAP-MR/DD	Other than CAP-MR/DD, what services are available for children or adults with developmental disabilities?	**Revised 3/13/06** State-funded services include case management, supported living, supported employment and long-term supports, ADVP, developmental day care, guardianship, and respite care. Medicaid-funded services include targeted case management. Please see Enhanced Services Implementation Update #2 at http://www.dhhs.state.nc.us/mhddsas/servicedefinitions/updates/dmadmh1-06update.pdf, and Enhanced Services Implementation Update #5 at http://www.dhhs.state.nc.us/mhddsas/servicedefinitions/updates/dmadmh2-23-06update5.pdf. Note: On March 6, 2006, the legally responsible representatives of Medicaid-eligible children with developmental disabilities were notified of the impending end of CBS and informed of options and provided with contact information for LME customer services offices, and urged to contact their case managers. See *Notice to Children with Mental Retardation/Developmental Disabilities Diagnosis Receiving Community Based Services* posted on 2/28/06 at

			http://www.dhhs.state.nc.us/mhddsas/announce/index.htm
53	Child and Adolescent Day Treatment	Can a client in day treatment program receive outpatient therapy from a therapist not employed with the day treatment program outside of the hours of the day treatment program?	The day treatment should take care of the treatment component unless there is a dual diagnosis and the recipient needs substance abuse treatment also.
54	Child and Adolescent Day Treatment	During the training it was mentioned that procedure code 90806, individual psychotherapy is a part of day treatment. The day treatment definition does not include therapy in the definition and therapy is not a service exclusion. If a child is receiving services through the day treatment program can they continue to see a private therapist who is billing Medicaid for therapy as a direct enrolled provider?, . If not, why is therapy not listed as a service exclusion? Why is therapy not listed as an intervention for day treatment?	The day treatment definition indicates this is a structured treatment program that provides mental health and substance abuse interventions in the context of a therapeutic milieu. Some of the specifics listed as: behavioral symptom management, therapeutic skill development, anger management, monitoring and self management of symptoms, and professional services on individual and group basis. The qualified professional to recipient ratio is 1 to 6. Except for medication management by a physician or nurse practitioner, there is no need for outside individual or group therapy.
55	Child and Adolescent Day Treatment	As part of day treatment, does each person need to complete a daily note?	Yes, a daily note needs to be completed for each child/adolescent in the program.
56	Child and Adolescent Day Treatment	Is a qualified professional required to be on staff in order to meet the staff to patient ration in day treatment? If an associated professional or a paraprofessional is running the group does a qualified professional need to be in the group?	A minimum of 1 QP staff to every 6 consumers is required to be present.
57	Child and Adolescent Day Treatment	Are residential services excluded from day treatment? The definition is unclear.	**Revised 3/13/06** Yes. Refer to the Enhanced Services Implementation Update #3 on DMH's website at http://www.dhhs.state.nc.us/mhddsas/announce/index.htm. Please note that in Update #3 the clarification reflects that

			Therapeutic Foster care is not excluded from Day Treatment. Note: On March 6, 2006, recipients currently receiving both Day Treatment and Residential services were provided in writing the opportunity to select either Day Treatment or Residential services, or to request a review of the need to continue to receive both services after March 20, 2006. See notice B, *Notice for Children Receiving Residential/Day Treatment* posted on 2/28/06 at http://www.dhhs.state.nc.us/mhddsas/announce/index.htm
58	Child and Adolescent Day Treatment	Is it true that day treatment does not cover education elements?	Educational skills that are usually taught in primary and secondary school settings are not reimbursable.
59	Child and Adolescent Day Treatment	Can behavior support be provided during education times?	Day treatment services include facilitating positive behavioral interventions that support daily functioning during educational activities.
60	Child and Adolescent Day Treatment	Day treatment staffing requires a 1 to 6 ratio for qualified professional staff to consumers but associate professionals and paraprofessionals can be part of the staffing team. Does the QP have to be present (in the room) for each group activity, or can the AP/PP staff be utilized to lead groups and other interventions?	This question assumes that the QP would be a part of the program staff and supervise the AP/PP staff. A minimum of one QP staff to every six consumers is required to be present. AP/PP staff can lead groups under the supervision of a QP.
61	Child and Adolescent Day Treatment	80% to 90% of the day treatment programs in the state including larger programs like Barrium Springs and smaller programs like Woodbridge bill six hours a day including academic time. These programs have a behavior program token system, and their staff involved the full day, but academics occur during the 6-hour period. Can these programs bill for the full 6- hour period including academic time?	No. Educational skills that are usually taught in primary and secondary school settings are not reimbursable.
62	Child and Adolescent Day Treatment	Who is the first responder for children in day treatment? The service definition does not indicate 24/7/365 coverage and only eight hours of CSS are covered per month, which is probably not enough for crisis coverage. Is there a maximum number of billing units that can be billed with HCPCS code H0014?	Additional services may be requested as medically necessity in a crisis situation.
63	Child and Adolescent Day Treatment	If a program contracts with the school system, can a teacher (degreed QP) lead a group focusing on a social skill bill for this hour even though she is a teacher but	We assume that the teacher is being paid by the school, and thus cannot provide more than one service at a time.

		is not leading an academic activity.	
64	Child and Adolescent Day Treatment	When do the new responsibilities for day treatment take effect since endorsement is not going to happen until March 20? When does the new rate become effective for day treatment?	The new responsibilities and rates for day treatment are effective at the time of your enrollment as a day treatment provider. Refer to Communication Bulletin #47 and to Enhanced Services Implementation Update #1 on DMH's website at http://www.dhhs.state.nc.us/mhddsas/announce/index.htm.
65	Child and Adolescent Day Treatment	Does the restriction on place of service for day treatment mean that a child in Level III cannot attend day treatment?	Yes. Refer to Enhanced Services Implementation Update #3 on DMH's website at http://www.dhhs.state.nc.us/mhddsas/announce/index.htm.
66	Child and Adolescent Day Treatment	Can the state change the place of service restriction on day treatment for children in Level III residential treatment?	**Revised 3/13/06** No. This was a CMS requirement. Note: On March 6, 2006, recipients currently receiving both Day Treatment and Residential services were provided in writing the opportunity to select either Day Treatment or Residential services, or to request a review of the need to continue to receive both services after March 20, 2006. See notice B, *Notice for Children Receiving Residential/Day Treatment* posted on 2/28/06 at http://www.dhhs.state.nc.us/mhddsas/announce/index.htm
67	Child and Adolescent Day Treatment	Can Level III residential treatment and day treatment be billed on the same date of service after March 19?	**Revised 3/13/06** No. Note: On March 6, 2006, recipients currently receiving both Day Treatment and Residential services were provided in writing the opportunity to select either Day Treatment or Residential services, or to request a review of the need to continue to receive both services after March 20, 2006. See notice B, *Notice for Children Receiving Residential/Day Treatment* posted on 2/28/06 at http://www.dhhs.state.nc.us/mhddsas/announce/index.htm
68	Child and Adolescent Day Treatment	Do providers have to be endorsed by the Local Management entity to provide day treatment?	Yes. Providers must be endorsed by the LME and enrolled with Medicaid.

69	Child and Adolescent Day Treatment	What are the eight units of community support provided through day treatment used for?	The eight units are for covered for admission, transition, and coordination of services for continuity purposes.
70	Child and Adolescent Day Treatment	Is it expected that community support would only be available for transition; does that mean no other community support can be offered?	Additional CS would be available as medically necessary, based on individual need.
71	Child and Adolescent Day Treatment	Is there a maximum number of units that can be billed for day treatment?	Day treatment is limited to a maximum of six hours per day up to five days per week.
72	Child and Adolescent Day Treatment	The service definitions for day treatment and residential treatment are different from the definitions that are on the website. Which version s correct?	This has been corrected on the web site.
73	Child and Adolescent Day Treatment	Are room and board covered for day treatment?	Room and board are not covered for day treatment and has never been included in the rate.
74	Clinical Home	Who is clinical home for these services?	Community support services are considered the clinical home.
75	Community Support	Do community support/CM services have to be provided 24/7?	**Revised 3/13/06** Yes. This service is the "clinical home" and is also the "first responder". Please note that case management is part of the Community Support service, and is not a stand-alone service for people with mental health and/or substance abuse needs. All adults and children with MH and/or SA diagnoses who are currently (prior to March 20, 2006) receiving CBS and case management services were provided in writing notification to select either their CBS or Case Management provider as their future Community Support provider, and to contact the customer service office at their LME. LMEs will acknowledge a recipient's selection of Community Support provider in writing or, upon no response from the recipient, will select an interim Community Support provider until the recipient makes the selection. See the Notices C1 & C2, and D1 & D2 posted on 2/28/06 at http://www.dhhs.state.nc.us/mhddsas/announce/index.htm
76	Community Support	Is there a limit of how much community support a recipient can receive?	Yes. Services are limited to a maximum of 32 units in a 24-hour period with no more than 112 units per week unless specific authorization by the LME/state vender to exceed this limit is approved.
77	Community	Who can provide the service orders? Do	Service orders may be provided by

	Support	they have to have mental health experience?	physicians, licensed psychologists, nurse practitioners, and physician assistant.
78	Community Support	What is the caseload limit for community support if the qualified professional serves adults (1 to 30) and children (1 to 15)?	The QP must be qualified to serve both populations, and the provider must be endorsed and enrolled to provide both services. Clinical documentation will reflect justification for the ratio, which must not exceed the limits described.
79	Community Support	If necessary (i.e., placements disruption) can more than 8 units be authorized for a child in residential care.	More than 8 hours of Community Support must be indicated by the PCP and authorized based on medical necessity.
80	Community Support	Can community support services be billed for individuals who are receiving behavioral counseling (either by the community support agent or a different agency) as long as the person-centered plan indicates both services?	Some types of clinical services would be provided by the community support provider, (e.g., supportive counseling). The case management function is also part of community support. If a person who is receiving Community Support requires individual therapy based on medical necessity and it is identified in the PCP, community support would assist the individual to arrange the needed service. If additional treatment is indicated in the PCP, such as substance abuse group therapy, that treatment can be provided.
81	Community Support	Are there be any restrictions to a qualified professional using 50% of their time rendering community support services (individual and/or group) and 50% of their time rendering outpatient therapy services for children and adolescents who are not linked to their community support work (but may be receiving community support from another community support professional)?	Community support service does not provide outpatient therapy. If the qualified professional is also an independent practitioner directly enrolled with Medicaid, that person may provide outpatient therapy for recipients who are not receiving community support from that same qualified professional. (p. 8)
82	Community Support	The Service Exclusions/Limitations for community support services indicates that community support services cannot be billed for individuals who are receiving Level II-IV child residential services. Is this referring to Program Type only or does it include Level II Therapeutic Foster Homes?	Level II Family type (i.e., Therapeutic Foster care) only is allowed.
83	Community Support Team	Will community support team services cover developmentally disabled individuals?	Community support team services can only be provided to a developmentally disabled individual if the consumer is a member of a mental health or substance abuse target population
84	Community Support Team	Where the staffing references indicate “the team must have at least .5 FTE team leader that provides clinical and administrative supervision of the team and also function as a practicing clinician on the team,” is this .5 FTE person one of the required 3 staff persons on the team?	The team leader is counted as one of the three staff.
85	Community	The staffing requirement for community	This is a team definition. It assumes that

	Support Team	support team services states that the consumer to practitioner ratio is no more than 15 consumers per staff person. For example, a team of 3 staff can have a caseload of 45 consumers" The other service definition for community support states that the qualified professional carries the caseload. Should this be interpreted to mean that the community support team (associated professional, paraprofessional, peer) can carry a caseload of 15 consumers? And, if so, is the qualified professional responsible for development of monitoring of all 45 plans?	staff functions as a team. The QP will be responsible for the PCP, but it is anticipated that others will be providing input and information about the consumer's progress during team meetings. Therefore, the consumer to staff ratio is 15 to 1 as specified in the definition.
86	Deaf and Hard of Hearing	Many services are broken down by scope of practice for the qualified professional and the associate professional or paraprofessional. Can the qualified professional provide services specified under both of these "scopes of practice" to clients who are deaf or hard of hearing since there may not be a readily available associated professional or paraprofessional that is versed in sign language?	Yes. The QP could carry out functions listed in the definition as in the scope of practice for AP and paraprofessionals but it would be an expensive way to deliver the service since the rate assumes that their will be staff with varied salary expectations. As with any service, the staff working with the individual should be trained or have the skills necessary to meet the needs of the individual and goals identified in the PCP.
87	Detox Services	How will the new detox service definitions apply to a hospital that that is licensed for more than 15 detox beds	If you are a general hospital and the recipient meets the medical necessity criteria for inpatient services, the service would be covered. If the hospital wants to bill one of the new services, the hospital would have to be enrolled as a detox facility and follow the restrictions of the service definitions. Refer to Clinical Coverage Policy #8B on DMA's website at http://www.dhhs.sate.nc.us/dma/mp/mpindes.htm.
88	Detox Services	Is non-hospital medical detoxification services are covered only for adults? What services are covered for children who require detox?	Yes. Non-hospital medical detox services are only covered for adults. Medically necessary services based on ASAM detoxification criteria are covered through ambulatory detox or hospital-based detox services.
89	Detox Services	Can an individual who is receiving non-hospital medical detoxification services receive opiod treatment at the same time?	Yes. The opiod treatment billing code is used to bill for the administration of the methadone.
90	Developmental Disabilities Services	Adult day treatment and developmental disability treatment services were not approved by CMS. What community based services for developmental disabilities will be covered/available after March 31, 2006?	**Revised 3/13/06** Specific strategies for addressing the needs of individuals with developmental disabilities receiving CBS have been identified. Please see Enhanced

			Services Implementation Update #2 at http://www.dhhs.state.nc.us/mhddsas/servicedefinitions/updates/dmadmh1-06update.pdf, and Enhanced Services Implementation Update #5 at http://www.dhhs.state.nc.us/mhddsas/servicedefinitions/updates/dmadmh2-23-06update5.pdf. Note: Medicaid-eligible adults with developmental disabilities who are currently receiving CBS were informed that Medicaid will not pay for CBS beyond March 19, 2006. Recipients were urged to contact their case managers and the LME customer service office to discuss service options. Please see *Notice for Adults with a Mental Retardation/Developmental Disability Diagnosis Receiving Community Based Services*, posted on 2/28/06 at http://www.dhhs.state.nc.us/mhddsas/announce/index.htm.
91	Developmental Disabilities Services	What happened to the services that were covered for developmental disability therapies?	Revised 3/13/06 The services were not approved by CMS. Please see Enhanced Services Implementation Update #2 at http://www.dhhs.state.nc.us/mhddsas/servicedefinitions/updates/dmadmh1-06update.pdf, and Enhanced Services Implementation Update #5 at http://www.dhhs.state.nc.us/mhddsas/servicedefinitions/updates/dmadmh2-23-06update5.pdf. All Medicaid-eligible consumers with developmental disabilities were informed that the Federal government at this time did not approve the service, Developmental Therapies, as a Medicaid covered service. These recipients were informed in writing on March 6, 2006 of their options and urged to contact their case managers and LME customer service office. Please see Notices E, F, and G, posted on 2/28/06 at http://www.dhhs.state.nc.us/mhddsas/announce/index.htm.
92	Developmental Disabilities Services	Some “non-Medicaid” (state funded/pioneer) consumers have been receiving developmental disability case management services from the Local Management Entities. Will the state fund targeted case management for non-eligible (Medicaid) consumers?	State funded case management will still be available.

		Where/who will provide this (only LME?) and how will consumers/families know what they are entitled to vs. what their rights are?	
93	Diagnostic Assessment	Is a new diagnostic assessment required if the community support team identifies day treatment as a needed service after the person-centered plan has been written?	No. However, an order must be written for the day treatment services and the PCP must be amended.
94	Diagnostic Assessment	Are employees with a Master in Arts for counseling and not fully licensed qualified to do conduct a diagnostic assessment?	No. There must be at least two licensed or certified clinicians. However, other professionals may contribute to the assessment.
95	Diagnostic Assessment	The Questions &Answers document for diagnostic assessment that is posted on the DMH/DD/SAS web page states that the nurse practitioner must be a certified psychiatric nurse. Is that still correct?	The nurse practitioner can sign the service order, but the certified psychiatric nurse currently can not. The certified psychiatric nurse can be the 2nd Qualified Professional for mental health since he/she is certified. For Substance Abuse and Developmental Disabilities staffing requirements see the Diagnostic Service definition.
96	Diagnostic Assessment	What does “access to psychiatric assessment” mean? Does and agency need to have a psychiatrist on staff to conduct an assessment or can there be someone in the community that can be used by the agency or the consumer if a psychiatric assessment is needed?	A provider may employ a psychiatrist, contract with a psychiatrist, or arrange for a consumer to obtain psychiatric care in the community when such a service is indicated within the PCP.
97	Diagnostic Assessment	Does the diagnostic assessment have to be completed before community support services cand be provided?	No. The diagnostic assessment is arranged and completed as part of the development of the PCP during a new consumer’s initial 30 days of service provision, which would usually be community support. The first 30 days of community support (and targeted case management, when approved) will serve to monitor the development of the PCP and the diagnostic assessment. Additional services may be requested as necessary through community support (and targeted case management) during the diagnostic assessment, prior to the completion of diagnostic assessment.
98	Diagnostic Assessment	Who can order the diagnostic assessment?	Diagnostic assessments can be ordered by MDs, Nurse Practitioners, Licensed Psychologist and Physician Assistants. Refer to the Questions and Answers on Diagnostic Assessments on DMH’s website at http://www.dhhs.state.nc.us/mhddsas/servicedefinitions/index.htm for additional information.

99	Diagnostic Assessment	Are both the qualified practitioner as well as the MD, DO, PA, NP, PhD,(PsyD) required to do the diagnostic assessment face–to-face with the client?	The diagnostic assessment team must include at least two QPs, according to 10A NCAC 27G.0104, both of whom are licensed or certified clinicians; one of the team members must be a qualified practitioner whose professional licensure or certification authorizes the practitioner to diagnose mental illnesses and/or addictive disorders.
100	Diagnostic Assessment	Are they allowed to do this separately, or do they have to perform the diagnostic assessment simultaneously with the client?	They can provide the service separately; however it can only be billed one time
101	Diagnostic Assessment	Whether done separately or simultaneously, which provider number should be used to bill for the service?	The diagnostic assessment agency that is enrolled with Medicaid to provide the services bills for the service using their provider number.
102	Diagnostic Assessment	The Diagnostic Assessment Questions and Answers published by DMH seem to differentiate diagnostic assessment from the evaluation service (90801). Is diagnostic assessment billed under a different code if it is a separate service from the evaluation?	Diagnostic assessment is billed with the code T1023. If the service is provided by a single practitioner as a stand alone service, it is not a diagnostic assessment; it would be billed with 90801, psychiatric interview. Refer to the Questions and Answers on Diagnostic Assessments on DMH's website at http://www.dhhs.state.nc.us/mhddsas/servicedefinitions/index.htm for additional information.
103	Diagnostic Assessment	Are current clients required to have a diagnostic assessment completed to receiving enhanced benefits services?	Yes. This is true for Medicaid clients. But, it is not necessary to complete the diagnostic assessment until the client's next annual plan review
104	Diagnostic Assessment	Can any diagnostic assessment or evaluation or testing be billed with day treatment or must they be billed separately?	These are separate services. The provider must be endorsed and directly enrolled separately for diagnostic assessment and day treatment and must be directly enrolled to do evaluation or testing.
105	Direct Enroll	Can you verify that PBH providers who are only providing enhanced benefit services within the PBH catchment area do not have to direct enroll with the state.	That is correct. PBH providers are enrolled with Piedmont. However, PBH providers who wish to provide services to recipients who are not in that catchment area must enroll with Medicaid and follow Medicaid's requirements

106	Direct Enroll	What is deadline for direct enrollment for new services? What is earliest date we can enroll? How do we obtain enrollment forms?	Agencies must seek endorsement from the LME first. After endorsement, the agencies attach a copy of their endorsement to a completed Medicaid application. Communication Bulletin # 47 and the Enhanced Services Implementation Update #1 are available on DMH's website (http://www.dhhs.state.nc.us/mhddsas/announce/index.htm) and provide information on the endorsement process, schedule and transition plan. Medicaid provider applications are available on DMA's website at http://www.dhhs.state.nc.us/dma/provenroll.htm.
107	Direct Enroll	If an agency is approved by Medicaid, but individual staff are not approved how will the agency bill for services?	It is the agencies responsibility to ensure that their staff meets the requirements indicated in the service definition. In order to bill Medicaid for a 'enhanced" benefit service the agency must meet the staffing mix as defined in the approved definition.
108	Direct Enroll	Does an agency need to enroll and obtain a separate provider number if you have sites with different medical records?	Yes. The federal government mandates the requirement that separate sites must enroll and bill with separate Medicaid provider numbers. A site is defined as the location where care is coordinated and records are housed.
109	Direct Enroll	Are there separate applications for each enhanced mental health services?	The Community Intervention Services provider enrollment application includes a checklist for providers to indicate the service for which they are applying. You may complete one application and attach all endorsements and indicate the services for which you are applying. If the agency has multiple physical locations where services are rendered and medical records are kept, then it is necessary to complete an application packet specific to each site that has been endorsed to provide services
110	Direct Enroll	Are hospitals required to go through the endorsement and application process?	Only if you want to provide one of these services
111	Direct Enroll	Is DMA ready to process enrollment packets?	Yes. The provider must be sure they receive endorsement prior to enrollment. Once endorsement is received, enrollment can occur.
112	Direct Enroll	How long does it take to complete the application process once the endorsement process has been	Applications that are received with all appropriate attachments and applicable endorsements can be processed within 3

		completed and the enrollment application has been sent to DMA?	to 5 weeks. However, DMA is already experiencing a high rate of applications that are incomplete or incorrect. These applications will be returned and the processing time may take much longer. Please be sure to review the application and instruction sheet thoroughly before submitting to DMA.
113	Direct Enroll	If a provider has enrolled with Medicaid to provide therapy and they want to provide diagnostic assessment, are they required to enroll and obtain a separate Medicaid provider number?	Yes. The provider agency must be endorsed and directly enrolled with DMA as a provider of diagnostic assessment. However, if you are currently enrolled to provide other services as a CIS provider with PIN 8300 at this location you may submit an addendum to the application and attach the applicable endorsement for Diagnostic Assessment.
114	Direct Enroll	How do I obtain a provider enrollment application for Community Intervention Services?	Applications are available on DMA's website at http://www.dhhs.state.nc.us/dma/provenroll.htm
115	Documentation	When providing community based services, is it required to document the recipient's Medicaid identification number on the medical record/service note?	CBS does not require the recipient's MID on documentation. Enhanced mental health services will require the MID.
116	Documentation	Is the attending each staff providing the service?	No you are looked at as an agency with this provider type since all of the services are provided by a team of individuals. The attending is the group provider number with the specific alpha for the service being provided. the group's core provider number i.e. 8300000 attending provider number with the specific alpha for example 830000B for the service being provided Community Supports in this example .
117	Documentation	Please clarify whether the recipient's Medicaid identification number or date of birth is required on each page of the medical record.	For enhanced mental health services, the MID number is required to be written on each page of clinical documentation
118	Documentation	Do we have to change current charts?	You cannot alter Medicaid records.
119	Documentation	Does the recipient's date of birth need to be on the medical record along with the Medicaid identification number?	Writing the date of birth on the medical record is not required for enhanced mental health services.

120	Documentation	What is the difference between the documentation requirement to note the "effectiveness of intervention" and the requirement to note the "progress towards goal?"	There is no difference in this documentation requirement. The effectiveness of the intervention would describe the impact of the intervention towards meeting the stated goal.
121	Documentation	What constitutes electronic medical record? In what circumstances is it sufficient to retain data electronically without a hard copy in medical record?	Providers may maintain electronic version of medical documentation if the entries are appropriately authenticated and dated with a unique identifier of a primary author who has reviewed and approved the entry. Entry of electronic signatures and codes must be made in a secure environment that protects the security of the patient information. Sanctions must be in place and imposed for improper or unauthorized use of code signatures. Providers must have a process in place for reconstruction of electronic records in the event of a system breakdown. It is the provider's responsibility to produce documentation with original signatures in the event that additional information is needed during a review of documentation related to the Medicaid claims.
122	Documentation	Where will the documentation policy be located?	Documentation requirements will be listed in Clinical Coverage Policy #8A on DMA's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm
123	Documentation	What constitutes an open record? Does an open record need to be established for a recipient who enters the system and is provided with community services for 30 days for DA?	Yes. Anyone who is receiving this service must have an open record.
124	Documentation	If more than one staff member is working with the client, who writes the service note?	The staff member who provides the intervention is responsible for writing the service note.
125	Documentation	Is the recipient's date of birth required on the claim form?	A Medicaid claim will not deny if the date of birth is left blank.
126	Documentation	What level of care document will be used for the new service definitions? The service definition for community support services for adults refers to AMH LOC; the services definition for community support services for children refers to CMH LOC; and the service definition fo day treatment services refers to LOC. The 2002 LOC document that providers have been lists CAFAS, which are no	The level of care document or ASAM PPC-II will guide the decision to determine medical necessity for admission as described in the service definitions.

		longer used.	
127	Documentation	Currently, the Local Management Entity is required to complete state forms like the Diagnostic Report, the Form B, and the Target Population Form. Will that requirement change with the implementation of the new services?	Currently, the provider is responsible for submitting the date to the LME; the LME is responsible to send the data to the DMH.
128	Documentation	Is the Medicaid identification number required on the service note and any other forms in the recipient's chart (i.e., Clients Rights, etc.)	The recipient's Medicaid identification number is required on all clinical information in the medical record
129	Endorsement	Info about windows – where can it be found?	Refer to Communication Bulletin #47 , Provider Endorsement Transition Plan on DMH's website at http://www.dhhs.state.nc.us/mhddsas/announce/index.htm for information.
130	Endorsement	Can a provider who has been endorsed by one Local Management Entity provide services to a recipient who has entered the system through a different Local Management Entity?	Endorsement is specific to each site and service not each consumer
131	Endorsement	Do providers need to wait until March 1 to submit endorsement packages to Local Management Entity for services that will be implemented on March 20?	No. But they will not have to begin until March 1.
132	Endorsement	What is conditional endorsement?	Conditional endorsement is a period of time in which the provider develops mastery of the services they are enrolling to provide. The conditional endorsement period can last up to 18 months
133	Endorsement	Do providers that did not receive endorsement when phase I was implemented need to obtain endorsement now?	No one can bill for a Medicaid service without endorsement. Providers need to submit endorsement requests and start the process; the LME will not be able to bill for new services for providers who are not endorsed.
134	Endorsement	Do direct enrolled therapy providers need to be endorsed?	Direct enrolled therapy providers do not need to be endorsed if that is the only service they will be providing
135	Endorsement	How are providers notified when the endorsement process has been completed?	An MOA and a Notification of Endorsement Action letter will be sent to the provider when the process has been completed. A copy of the endorsement letter must be attached to the provider enrollment application that is submitted to Medicaid.
136	Endorsement	If a provider is endorsed to provide DA can they also be endorsed to provide SACOT?	Yes, if all requirements are met for both services.
137	Endorsement	When completing an endorsement for a site or services, can a local Management Entity ask for information that is not on	No. Endorsement also requires review of core DMH/DD/SAS rules if the service does not require a license.

		the checklists?	
138	EPSDT	What are the basic requirements for EPSDT?	EPSDT applies only to recipients under the age of 21. 1. The service, product, or procedure must be medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening examination. 2. The service, product, or procedure must not be experimental/investigational. 3. The service, product, or procedure must be safe? 4. The service, product, or procedure must be effective. 5. The service, product, or procedure must be covered under 1905(a) of the Social Security Act. ALL of these criteria must be met in order for DMA to approve the request. CMS specifies that states do not have to approve experimental/investigational, unsafe, and/or ineffective services, products, or procedures. Once it has been determined that DMA will approve the request, the amount or frequency of the service requested must be evaluated. Health care services will be provided in a frequency and amount consistent with the recipient's medical needs. That is, if 100 units of a particular product were requested but the reviewer determined 50 units will meet the recipient's needs, DMA has the authority to approve the request and to authorize a frequency or amount that will meet the recipient's needs based on medical necessity. The example illustrates an approval with a reduction of the request. Due process (appeal) rights are required and would be issued to the recipient. For additional information, refer to the December 2005 Special Bulletin on DMA's website at http://www.dhhs.state.nc.us/dma/bulletin.htm.
139	EPSDT	In the event that a request exceeds the established limits for the service, product or procedure, is DMA approval required.	Yes, address the request to the Assistant Director for Clinical Policy and Programs. DMA may consult with and/or forward the request to DMH for a response. For additional information, refer to the December 2005 Special Bulletin on DMA's website at http://www.dhhs.state.nc.us/dma/bulletin.

			htm.
140	EPSDT	Is there any latitude for local approval for EPSDT?	No
141	Facility-based Crisis Program	What is the rate for professional treatment services in facility based crisis programs?	The per hour rate for Crisis Intervention (Facility Based Crisis) HCPCS code S9484 is 18.78 as of 03/20/2006.
142	Facility-based Crisis Program	What are the staffing requirements for facility based crisis programs?	The service is provided under the direction of a physician. For adult mental health services, the ratio is 1 staff to 6 consumers. For adult substance abuse services, the ratio is 1 staff to 9 consumers,
143	First Responder	What are the First Responder requirements for facility based crisis programs?	Facility based crisis programs must have policies in place and the capacity to carry out first responder activities for their recipients on a face-to-face basis and also telephonically at all times (24/7/365) with capacity for face-to-face emergency response within 2 hours.
144	Intensive In-Home	With the number of rural areas that have no licensed staff available and a driving distance of 30 miles or more to the closest licensed staff, how will it be possible to provide outpatient services and intensive in-home services throughout the state? Will a clinical override to utilize a qualified professional apply in cases like this for children under 21?	There is no clinical override for rural areas.
145	LME	Does a Local Management Entity have to have site-specific provider numbers and service-specific provider numbers?	Yes. LMEs must have a provider number for each service that they provide and for each location where the service is provided.
146	LME	How may Local Management Entities will there be?	There is no target number.
147	LME	If the community does not have a provider for a specific service (e.g., SA IOP), what is the LME's responsibility to ensure that this service provided?	The LME is responsible for developing a network that meets the community's need and offers choice to the recipient.
148	LME	What if a provider works with multiple management entities including Piedmont?	The provider will follow Piedmont guidelines for recipients in that catchment area and state guidelines for the rest of the recipients they serve.

149	Medicare	If the provider does not have a Medicare provider number, and the client has both Medicare/Medicaid, will Medicaid reimburse for this service?	No. Medicaid is the payer of last resort. If the service is covered by Medicare, Medicare must be billed first.
150	Medicare	Do providers have to bill Medicare/other primary insurance and get denial for these services prior to billing Medicaid? If the service is a bachelors level service (community support) that Medicare does not cover when provided by bachelors level staff, how will a provider submit the claim to Medicaid for payment?	A list of the codes/services that Medicaid will override for Medicare and THIRD PARTY LIABILITY will be developed. If the service is not on that list, then it must be billed to Medicare/other primary insurance first because Medicaid is always the payer of last resort.
151	Medicare	If a client has Medicaid and Medicare Part A and Part B and is receiving outpatient A treatment 2 therapy in a facility without a full time physician, will Medicaid reimburse for the service after the service is denied by Medicare?	Not if it is a Medicare covered service
152	Medicare	If a provider is not able to enroll in Medicare, can the provider still bill Medicaid?	No. Providers who are not enrolled with Medicare cannot bill Medicaid for a service that is covered by Medicare. If the service is a service that must be billed to Medicare first and the recipient has Medicare, the provider must be enrolled with Medicare and Medicaid in order to bill for the recipient
153	Medicare	If a service is billed to Medicare and is denied as non-covered, can the service then be billed Medicaid?	Yes. If the service is denied by Medicare as non-covered the provider can then file the claim to Medicaid and ask for a Medicare override. The provider must submit the claim along with a completed Medicaid Resolution Inquiry Form, the denial from Medicare, and the description of the denial.
154	Mobile Crisis Management	Where can providers obtain the "crisis rating scale specified by DMH," which is necessary for Mobile Crisis Management services?	Mobile Crisis Management may use a crisis rating scale, approved by the DMH/DD/SAS.
155	Mobile Crisis Management	Can HCPCS code H2011 for Mobile Crisis Management be provided and billed to Medicaid with a public school indicated at the place of service?	Yes. If the service was provided at that location, it should be billed with that place of service code. But medical necessity must still be met.
156	Other Services	Can we bill for neuro feedback?	No. This is not a covered service.

157	Other services	Is CD Rehab service covered when it is provided in a hospital setting with more than 16 beds?	No. Only acute detox is provided in a hospital setting.
159	Outcomes	How will the change in the number of Local Management Entities impact TOPP's numbers, which are used for input and outcomes? Will the facility code change?	TOPPS uses the DMH/DD/SAS facility number.
160	Partial Hospitalization	Has coverage for partial hospitalization services been discontinued?	No. Partial hospitalization services were addressed in Phase I.
161	Person Centered Plan	Is there a format for the crisis plan?	When the PCP format is announced it will provide guidance concerning crisis plans
162	Person Centered Plan	Will the state specify a format for Person Centered Plan document	A format will be developed for use for these services except for those services provided to CAP recipients. Providers will continue to follow the plan format indicated in the CAP waiver for CAP recipients.
163	Person Centered Plan	Will the Division of MH/DD/SAS actually develop and distribute a form for the PCP or just provide requirements and guidelines?	Yes. A form will be developed.
164	Person Centered Plan	Does person-centered training apply to outpatient providers who are direct enrolled?	Providers who are billing for basic benefit services are not required to complete a person centered plan, although they are required to have a treatment plan pertinent to their treatment of the recipient.
165	Person Centered Plan	Can services be provided before the person-centered plan ahs been completed?	The recipient should begin receiving the appropriate service(s) until a diagnostic assessment and PCP can be developed.
166	Person Centered Plan	When will the template for the person centered plan, transition plans, and crisis plan be available and what will be the time frame for all consumers who receive enhanced services to have this plan is their medical records.	The PCP template and crisis plan elements will be published on DMA's website as soon as possible. Refer to medical records manual. An updated version will be available soon.
167	Provisional Licensed	Will qualified professionals continue to be able to bill BHC services (HCPCS code H0004) through the Local Management Entity?	Non-licensed and provisional licensed will be allowed to bill through the LME until September 20, 2006.

168	Provisional Licensed - Trainees	The enhanced services do not accommodate training programs for clinical psychologists at the doctoral level. Is there a plan for exceptions of additional services that will afford trainees exposure to Medicaid populations and their needs, especially to outpatient mental health services such as therpay?	Yes. A workgroup has been established by DMH/DD/SAS with representatives from the statewide professional associations.
169	Psychiatric Residential Treatment Facility	Can a psychiatric residential treatment facility bill for discharge planning as a community support service?	Community support can be billed for a maximum of 8 units per month for the purpose of facilitating transition or coordination.
170	Psychiatric Residential Treatment Facility	Who does discharge planning when a client is in a psychiatric residential treatment facility?	Community support can be billed for a maximum of 8 units per month for the purpose of facilitating transition or coordination.
171	Substance Abuse Medically Monitored Community Residential Treatment	The staffing requirements for substance abuse medically monitored community residential treatment states that a registered nurse must be available to conduct a nursing assessment and monitor the patient's progress on an hourly basis but it does not give the duration?	Registered nurse coverage is required on site 24/7/365.
172	Substance Abuse Non-Medical Community Residential Treatment	According the service definitions, substance abuse non-medical community treatment is limited to 30 days per year. Perinatal and CASAWORKS program model requires longer treatment. Was the 30 day limit an error?	No. This limitation was required by CMS. We recognize this is a problem and will negotiate that issue within DHHS.
173	Substance Abuse Non-Medical Community Residential Treatment	Does Medicaid cover adolescent substance abuse non-medical community residential treatment? What services are available for adolescents who might need medical detoxification services?	Substance abuse non-medical community residential treatment services are not covered for adolescents. Acute inpatient services should be available to provide medical detox for adolescents.
174	Substance Abuse Non-Medical Community Residential Treatment	Are substance abuse non-medical community residential treatment services covered for adolescents?	No.
175	Substance Abuse Non-Medical Community Residential Treatment	Can state funds be used to pay days that exceed the 30-day limit for non-medical community residential.	No.

176	Substance Abuse Services	Are services limited to 15 days per episode or 30 days per month?	All of the substance abuse residential services that are being implemented have a 30-day per 12-month period restriction. Facility based crisis services are limited to 15 days per episode limit but cannot exceed more than 30 days in a 12-month period. Begin a transition plan right now. On March 20, 2006, additional services within this setting may be authorized for up to 30 days as medically necessary.
177	Substance Abuse Services	Left deliberately blank	Left deliberately blank
178	Substance Abuse Services	When completing the enrollment application for Community Intervention Services, do all of the employees need to be listed on the application?	No. The agency should complete the application. As the services have a mix of staff, the LME will assure Medicaid through the endorsement that the "agency" has adequate staff to perform according to the definition for each service requested.
179	Substance Abuse Services	Can CASA works bill more than 30 days?	A guidance document will be forthcoming from the DMH/DD/SAS regarding these programs.
180	Substance Abuse Services	Is a recipient under the age of 21 with a substance abuse problem eligible for services from a psychiatric residential treatment facility instead of another residential program?	Yes.
181	Substance Abuse Services	Does the (Licensed Clinical Addiction Specialist (LCAS) need to be on site 8 hours per day? What if the LCAS does not want to work 7 days/wk?	The program must be under the clinical supervision of an LCAS or Certified Clinical Supervisor (CCS) who is onsite a minimum of 8 hours per day when the service is in operation and available by phone 24 hours per day.
182	Substance Abuse Services	Substance abuse services can only be provided in license facility – is it site specific?	All SA facilities must be licensed. Community Support does not require a license for Substance Abuse. The license is for the specific location
183	Substance Abuse Comprehensive Outpatient Treatment (SACOT)	March 20 SACOT → staffing – Certified Clinical Supervisor (CCS) or LCAS days need to be on site 90% is this correct.	Yes.
184	Substance Abuse Comprehensive Outpatient Treatment	Can substance abuse comprehensive outpatient treatment services be provided to a recipient from two different sites operated by the same agency?	No. Endorsement, enrollment and billing are site specific. Medicaid requires site specific (where services are coordinated and medical records are housed) enrollment. Each site must meet enrollment guidelines for services they wish to provide.
185	Substance Abuse ComprehensiveOutpatient Treatment	How does an agency bill for substance abuse comprehensive outpatient treatment services if the client receives one hour of counseling in the agency's office and then 3 hours of group therapy	Endorsement, enrollment and billing are site specific. SACOT must be provided at a single location. Each location must have the appropriate endorsement, licensure, and be enrolled with Medicaid

		at the agency's clinic?	to bill for services rendered at the site. SACOT must be provided at a single location.
186	Substance Abuse Comprehensive Outpatient Treatment	Will LCASs and qualified professionals be allowed to provide services in a community support program, for example, and also provide substance abuse comprehensive outpatient treatment as needed? Are there "firewalls" between programs to prevent this?	Each service definition requires the provider to separately meet the staffing requirements for that service. These functions cannot be provided at the same time by the same individual.
187	Substance Abuse Comprehensive Outpatient Treatment	Are providers required to bill 4 hours of service a day?	A minimum of 4 hours must be provided and billed in order to receive reimbursement for this service.
188	Substance Abuse Intensive Outpatient Program	Do times include break time in billing for IOP?	No. Medicaid only covers face–to-face time.
189	Substance Abuse Intensive Outpatient Program	If doing 9 hours a week SAIOP-how much is 50% that CCS or LCAS needs to be on site?	LCAS or CCS is required to be on-site a minimum 50% of the hours the service is in operation. The intent was on a daily basis.
190	Substance Abuse Intensive Outpatient Program	Is a new service order and authorization for service required if a recipient drops out before the authorized services have ended? For example, a recipient is authorized for 12 weeks and drops out after 2 weeks then returns a month later.	If the consumer returns a month later, a new service order and authorization for service is required.
191	Substance Abuse Intensive Outpatient Program	Best practice SAIOP is 16 weeks, is it possible to get extended to 16 weeks? And then after care?	The initial authorization for services cannot exceed a duration of 12 weeks. Under exceptional circumstances one additional reauthorization up to two weeks can be approved. The aftercare would be a step down to Community Support or CST.
192	Substance Abuse Intensive Outpatient Program	Can the services be tapered down to less than 3 hours per day?	SAIOP must be provided a minimum of 3 hours a day, 3 days per week. This service can only be tapered if the program is being offered more than the minimum number of hours or days per week.
193	Substance Abuse Intensive Outpatient Program	If a provider wants to provide only 1½ hour of services a day, can they bill something other than substance abuse intensive outpatient?	SAIOP requires participation for a minimum of 3 hours per day. No other service is authorized to be billed during that time.
194	Substance Abuse Intensive Outpatient Program	IF the recipient does not attend substance abuse intensive outpatient services for 3 hours per day can the service still be billed?	No. SAIOP requires participation for a minimum of 3 hours per day.
195	Substance Abuse Intensive Outpatient Program	Explain the 12 wk per episode?	SAIOP is a 12 week service.
196	Substance Abuse Intensive Outpatient Program	Are substance abuse intensive outpatient services billed as an event or unit?	SAIOP is billed per event. An SAIOP event is equivalent to a minimum of 3 hours of service in a day.

197	Substance Abuse Intensive Outpatient Program	Does the 2 day lapse mean holidays ?	Yes.
198	Service Orders	Service Order-day of or prior to what if have a physician who has contract with standing order –will this work?	Service orders must be written on or before delivery of service, and will be reviewed, at least, on a yearly basis.
199	Service Orders	When will orders for the new service categories be required for existing clients?	Service orders will be required to initiate any service that the consumer has not previously received.
200	Service Orders	Do the new services require a new service order beginning March 20?	Refer to the Enhanced Services Implementation Update #3 on DMH's website (http://www.dhhs.state.nc.us/mhddsas/announce/index.htm) for instructions on crosswalking existing services to new services.
201	Service Orders	There are discrepancies as to how Local Management Entities define a "week". Is there a daily maximum number of hours for personal care services (S5125)? Is there a daily maximum number# hours for home and community supports (H2015)?	A week is defined as seven consecutive days, from the day of reference. PCS providers must adhere to CAP-MR/DD utilization review guidelines and the PCP process. Home and community supports must adhere to CAP-MR/DD utilization review guidelines and the PCP process.
202	Targeted Case Management	Is targeted case management being implemented at this time?	Targeted Case Management for MR/DD is not a part of this implementation process. It has its own schedule. Targeted Case Management for mental health and substance abuse will be replaced when community supports are implemented.
203	Targeted Case Management	Can a case management provider also contract with or employ a direct enrolled provider who is providing and billing for therapy services that they provide to a recipient? In other words, can a recipient receive both therapy and case management from the same provider?	No. The only service that can be combined with TCM is diagnostic assessment.
204	Targeted Case Management	The service definitions for these enhanced mental health services state that services are ordered by a physician, licensed psychologist, nurse practitioner or physician assistant. In the past, a qualified professional could order case management services. Has this requirement changes for targeted case	In regard to TCM, the service has not yet been approved by CMS and therefore their current process would continue for the service order.

		management services changed? In the letter from Mike Moseley and Allen Dobson, it notes if there are not changes in the PCP and only changes in the service name, the practitioner should record the name of the new service, sign and date the PCP/treatment plan. Is the consumer/legal guardian required to sign and date this change?	
205	Training	There are not enough trainers identified across the state especially in rural areas. Is the Division still seeking applicants for "training of trainers" on the new community support services?	Yes. Refer to Communication Bulletin #33 on DMH's website at http://www.dhhs.state.nc.us/mhddsas/announce/index.htm for an application and additional information. The application allows applicants to indicate the service(s) they are interested in being trained for.
206	Training	What are the requirements for trainers?	According to the application, a trainer is required to have a masters degree and training experience with the population that is served by the service they wish to be for. References are required. Refer to Communication Bulletin #33 on DMH's website at http://www.dhhs.state.nc.us/mhddsas/announce/index.htm for an application and additional information.
207	Training	What constitutes the 20 hours of training?	An announcement from DMH on the training requirements is forthcoming.
208	Training	Are the training requirements the same for all of the enhanced services?	Training requirements are specific to the service. Refer to each service definition for specific training requirements.
209	Training	Who is responsible for getting the training?	The providers and/or the LME providing services.
210	Training	Can the IDDT tool kit be provided in community support services?	Yes, depending on the individual and their needs. It is possible for the paraprofessional to teach the skills within IDDT while using the strategies as the framework to implement.
211	Training	Will training on the implementation of Phase I be provided?	Training on Phase I was held across the state in October 2005. The September 2005 Special Bulletin addresses the services that were discussed. The special bulletin is available on DMA's website at http://www.dhhs.state.nc.us/dma/bulletin.htm.
212	Training	Are CAP MR/DD also required to obtain 20 hours of training? Are guidelines available?	There are no training requirements for CAP providers. Staff providing CAP services should attend trainings based on their consumers' needs and the supports indicated by the PCP

213	Training	Will there be training provided for PCP and crisis plans to ensure that Medicaid guidelines are met for those plans?	Yes.
214	Training	Will clinicians be required to have training in order to develop PCP and crisis plans and provide the services? What isa the time frame for completing the training? Will the training be provided by the Local Management Entity or DMH? Can there be more local sites scheduled for the trainings?	The staff who are responsible for developing the PCP and crisis plans are encouraged to attend training to understand what is required. Some services require PCP and crisis plan training to meet the required hours of training. According to the service definitions check sheets used in the endorsement process, a person delivering one of the new enhanced services will have up to 18 months to complete their training. The maximum of 18 months coincides with the provider having 18 months to complete full endorsement. Training for the new enhanced services definitions will be provided by: Behavioral Healthcare Resource Program, Developmental Disability Training Institute and numerous trainers who have completed the endorsed training curriculum. Refer to Communication Bulletin #33 on DMH's website at http://www.dhhs.state.nc.us/mhddsas/announce/index.htm for additional information.
215	Training	Will training on diagnostic assessment be offered?	Yes. See previous answer for resources
216	Training	When and where will the 20 hours of training on community support services be scheduled?	An announcement from DMH on the training requirements is forthcoming.
217	Training	Please clarify what is required with the 20-hours of training. Does the training have to be definition specific or just will it focus on the population served?	There will be designated training criteria for the service definitions requiring 20 hours. There are only 3 new enhanced service definitions that require 20 hours of training: Community Support Community Support Team Mobil Crisis
218	Training	When will we receive a detailed breakdown on what the 20 hours of training will consist of? If 6 of the training hours are definition oriented, what will the remaining other 14 hours focus on? What is the current capacity for trainers statewide? How many trainers will there	DMH will announce the training requirements and is working in conjunction with 2 training management agencies to train additional staff to assist with the training needs. We anticipate that very shortly we will have an additional 65 trainers in the field.

		be? How many persons (trainees) can register for each class? How will providers be updated on future trainings for community supports? How do providers get a (master's level) representative from their agency trained in order for that representative to be able to train their staff?	Providers are invited to access Communication Bulletin #33 from DMH's website (http://www.dhhs.state.nc.us/mhddsas/announce/index.htm) and apply to become a trainer of the new enhanced service definitions For updates on training opportunities please refer to the Behavioral Healthcare Resource Program and Developmental Disability Training Institute websites.
219	Training	What is included in the 20 hours of trainings for the new services, such as community support servces.	An announcement from DMH on the training requirements is forthcoming.
220	Training	How will our staff meet the training requirement without available state endorsed trainers to conduct trainings?	It is the responsibility of the 2 agencies mentoring the potential trainers to notify DMH when the trainers have completed their training requirements. Once the potential trainees have completed their required training they will be issued a letter for the DMH endorsing them to go forward and begin training across the state.
221	Transition to New Services	Some codes are covered for different treatments (for example, H0036 and H0036HQ). With the implementation of community support services will coverage of Community Based Services end on March 20?	**Revised 3/13/06** Yes. The codes that are billed CBS will no longer be available for services delivered after March 19, 2006. All consumers receiving CBS were provided in writing notification that Medicaid will not pay for CBS services beyond March 19, 2006. Recipients were instructed to contact their LMEs immediately to discuss how this change affects their services. Recipients under the age of 21 years were provided the opportunity in writing to have Medicaid reconsider and review the decision to end CBS. Recipients with any questions were also given the opportunity to contact the LME customer service office. CAP-MR/DD recipients currently receiving CBS have been told in writing that payment for CBS will end on March 19, 2006. They are instructed to talk with their case manager and the LME customer service staff about service options. See the Notices C1 & C2, D1 & D2, E, F, and G (for CAP-MR/DD recipients) posted on 2/28/06 at http://www.dhhs.state.nc.us/mhddsas/announce/index.htm

222	Transition to New Services	With the implementation of community support service, will coverage of mental health/substance abuse case management end on March 20 or may we continue to bill T1017HE for six months following March 20?	**Revised 3/13/06** MH/SA case management will no longer be available for services delivered after March 19. 2006. All adults and children with MH and/or SA diagnoses who are currently receiving CBS and case management services were provided in writing notification to select either their CBS or Case Management provider as their future Community Support provider, and to contact the customer service office at their LME. LMEs will acknowledge a recipient's selection of Community Support provider in writing or, upon no response from the recipient, will select an interim Community Support provider until the recipient makes the selection. See the Notices C1 & C2, and D1 & D2 posted on 2/28/06 at http://www.dhhs.state.nc.us/mhddsas/announce/index.htm
223	Transition to New Services	What is the cut-off date for current services? Is there a transition period during which both the old and the new services will be covered?	**Revised 3/13/06** This is addressed in the Enhanced Services Implementation Update #1 on DMH's website at http://www.dhhs.state.nc.us/mhddsas/announce/index.htm. The last possible date to bill for the old services is March 19, 2006. On March 6, 2006, all recipients were informed in writing about the impact of the service definition changes on their current services. They were instructed to contact their case managers and LME customer services staff with any questions regarding their service options. Please see the Notices posted on 2/28/06 at http://www.dhhs.state.nc.us/mhddsas/announce/index.htm.
224	Transition to New Services	How will the authorization process work for Community Based Services and community support services?	The authorization process has not yet been finalized.
225	Transition to New Services	How will recipients who are getting case management and Community Based Services be transitioned to community support services?	**Revised 3/13/06** A crosswalk has been described in Service Definition Implementation Update #3 on DMH's website at http://www.dhhs.state.nc.us/mhddsas/announce/index.htm. All consumers receiving CBS and case

			management were provided in writing notification of the options available to them based on age and diagnosis. Recipients were instructed to contact their LMEs immediately to discuss how this change affects their services. Recipients under the age of 21 years were provided the opportunity in writing to have Medicaid reconsider and review the decision to end CBS. Recipients with any questions were also given the opportunity to contact the LME customer service office. CAP-MR/DD recipients currently receiving CBS have been told in writing that payment for CBS will end on March 19, 2006. They are instructed to talk with their case manager and the LME customer service staff about service options. See the Notices C1 & C2, D1 & D2, E, F, and G (for CAP-MR/DD recipients) posted on 2/28/06 at http://www.dhhs.state.nc.us/mhddsas/announce/index.htm
226	Transition to New Services	Is a referral needed for children under the age of 5 who were covered under Health Choice and transitioned to Medicaid?	Yes. If the child was covered under Health Choice and is now covered by Medicaid, providers must follow all Medicaid procedures including obtaining referrals where appropriate.
227	Transition to New Services	Is there a transition period between the old services and the new services?	This is addressed in the Enhanced Services Implementation Update #1 on DMH's website at http://www.dhhs.state.nc.us/mhddsas/announce/index.htm. The last possible date to bill for the old services is March 19, 2006.
228	Transition to New Services	Will facility based crisis program for recipients under the age of 21 no longer be available after March 20?	CMS offered PRTF as alternative.
229	Transition to New Services	How will recipients receiving mental health case management receive services after March 20?	**Revised 3/13/06** Consumers will transition from MH targeted case management to Community Support. Refer to the Enhanced Services Implementation Update #3 on DMH's website at http://www.dhhs.state.nc.us/mhddsas/announce/index.htm for information on service transition. All consumers receiving case management and CBS were provided in writing notification of the options available to them based on age and diagnosis. Recipients were instructed to contact their LMEs immediately to discuss how this

			change affects their services. Recipients under the age of 21 years were provided the opportunity in writing to have Medicaid reconsider and review the decision to end CBS. Recipients with any questions were also given the opportunity to contact the LME customer service office. CAP-MR/DD recipients currently receiving CBS have been told in writing that payment for CBS will end on March 19, 2006. They are instructed to talk with their case manager and the LME customer service staff about service options. See the Notices C1 & C2, D1 & D2, E, F, and G (for CAP-MR/DD recipients) posted on 2/28/06 at http://www.dhhs.state.nc.us/mhddsas/announce/index.htm
230	Transition to New Services	What guidelines do we follow after March 20 for services that have already been implemented such as ACTT?	For ACTT, effective March 20, you must be endorsed and directly enrolled and meet the requirements of the new service definition.
231	Transition to New Services	How does the state plan to transition from the current system of case management to the new services?	**Revised 3/13/06** Refer to the Enhanced Services Implementation Update #3 on DMH's website at http://www.dhhs.state.nc.us/mhddsas/announce/index.htm for information on service transition. All consumers receiving case management and CBS were provided in writing notification of the options available to them based on age and diagnosis. Recipients were instructed to contact their LMEs immediately to discuss how this change affects their services. Recipients under the age of 21 years were provided the opportunity in writing to have Medicaid reconsider and review the decision to end CBS. Recipients with any questions were also given the opportunity to contact the LME customer service office. CAP-MR/DD recipients currently receiving CBS have been told in writing that payment for CBS will end on March 19, 2006. They are instructed to talk with their case manager and the LME customer service staff about service options. See the Notices C1 & C2, D1 & D2, E, F, and G (for CAP-MR/DD recipients) posted on 2/28/06 at http://www.dhhs.state.nc.us/mhddsas/announce/index.htm

232	Transition to New Services	Who can be served under the community support services definition?	Please refer to to DMH's website at http://www.dhhs.state.nc.us/mhddsas/announce/index.htm for information implementation updates and communication bulletins. The approved service definitions are also available online at http://www.dhhs.state.nc.us/mhddsas/servicedefinitions/index.htm.
233	Transition to New Services	What is the time frame for transitioning from case management services to community support services?	**Revised 3/13/06** MH/SA Case management expires on March 19, 2006; Community Support begins on March 20, 2006. On March 6, 2006, all consumers receiving case management and CBS were provided in writing notification of the options available to them based on age and diagnosis. Recipients were instructed to contact their LMEs immediately to discuss how this change affects their services. See # 231 above for further information.
234	Training Documents	Where can I find a copy of the service definitions?	The service definitions are available online at http://www.dhhs.state.nc.us/mhddsas/servicedefinitions/index.htm.
235	Training Documents	Where can I find a copy of the Phase II Enhanced Benefits seminar presentation? Is it available online?	The slide presentation is not available online. However, the January 2006 Special Bulletin that used during the seminar is available on DMA's website at http://www.dhhs.state.nc.us/dma/bulletin.htm.
236	Training Documents	Where can I find a copy of the October 2005 Phase I Enhanced Benefits seminar presentation? Is it available online?	The slide presentation is not available online. However, the September 2005 Special Bulletin that was used during the seminar is available on DMA's website at http://www.dhhs.state.nc.us/dma/bulletin.htm.